# FORMULATION OF A BUSINESS PLAN FOR A NURSE PRACTITIONER-DRIVEN OUTPATIENT PALLIATIVE CARE CLINIC

By

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# Formulation of a Business Plan for a Nurse Practitioner-Driven Outpatient Palliative Care Clinic

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## Abstract

**Background:** Palliative care is specialized, patient-centered health care for people with life-limiting or terminal illness that focuses on relief of symptoms and stress, and providing comfort with the primary goal of improving quality of life for patients and their families (Center to Advance Palliative Care, 2015). In 2009, Meier (2011) reported that palliative care saved $1.2 billion annually over standard care. Advanced Practice Registered Nurses (APRNs) have a "proven track record" of providing cost-effective quality care to populations across the lifespan (Institute of Medicine, 2010). APRNs provide holistic care to individuals and their families to evaluate and manage symptoms and provide comfort that promotes quality of life for as long as possible.

**Problem:** Although empirical evidence demonstrates significant benefits to quality of life and reduction of 30-day hospital readmissions with the intervention of palliative care, outpatient palliative care is not sufficiently available in the targeted metropolitan area. The National Priorities Partnership report identified palliative care as one of six priority areas that would significantly improve the quality of American health care (Meier, 2011).

**Project Aim:** The purpose of this practice change project was to develop a business plan that determined the feasibility of an outpatient palliative care nurse practitioner-driven clinic.

**Project Method:** Formation of a business plan according to the United States Small Business Administration model, which has six components. Current scholarly evidence related to quality of life and 30-day hospital readmissions was synthesized in preparation for development of the business plan.

**Findings and Conclusion:** The business plan supports the feasibility of a nurse practitioner outpatient palliative care clinic in addition to traditional care in the Kansas City metropolitan

area as a means to increase accessibility to palliative care and to: 1) improve quality of life for patients and families, 2) reduce 30-day hospital readmissions for patients with life-limiting illness.

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## Background

The World Health Organization (2017) describes palliative care for patients and families facing life-limiting illness as an approach to preventing and relieving suffering and improving quality of life. Palliative care is an emerging specialty. In 2006 the American Board of Hospice and Palliative Medicine achieved recognition for the subspecialty of Hospice and Palliative Medicine by the American Board of Medical Specialties (American Academy of Hospice and Palliative Medicine). As of 2015, there were only 6,500 physicians who were board-certified in hospice and palliative care (The EDITORS, June, 2015). The 2008 National Priorities Partnership (NPP) report identified palliative care as one of six priority areas that would significantly improve the quality of health care (Meier, 2011). Kavalieratos (2016) and Ranganathan (2013) provide evidence that patients and families who receive palliative care services have shown improvements in quality of life and a reduction in 30-day hospital readmissions, respectively.

According to the American Nurses Association (2015), "Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations" (paragraph 1). Nursing and palliative care meld to create the ideal avenue for nurse practitioners to function at the top of their licensure to impact patient care and quality of life. APRNs provide holistic care to individuals and their families to evaluate and manage symptoms and provide comfort that promotes quality of life for as long as possible (Hospice and Palliative Nurses Association [HPNA], 2015).

In 2001, the Institute of Medicine (IOM) issued a call for improvement of healthcare quality. The report, *Crossing the Quality Chasm: a New Health System for the 21st Century,*

detailed a great divide between what is known and taught to be good quality health care and the health care that is actually delivered in the United States. The six "Aims for Improvement" outlined in the report called for safe, effective, patient-centered, timely, efficient, and equitable health care. Nurse practitioners have been noted by The American Association of Nurse Practitioners (AANP) to provide high-quality, cost-effective, efficient and equitable patient-centered health (2015). Nurse practitioner palliative care can increase access to palliative care and efficiency of delivery. Palliative care by definition is patient-centered, and it must be timely. It is a safe and effective way to meet patient and family needs in patients with life-limiting illness (Meier, 2011).

Palliative care is effective, timely, efficient, equitable, and patient-centric at its core. Morrison and Associates (2008) calculated a net savings of $4,908 per patient death for patients receiving palliative care services in the hospital. Outpatient palliative care provides ongoing symptom management, patient and family advanced care planning, and nearing end-of-life support outside the hospital. Currently more than 40% of Medicare beneficiaries are documented as being enrolled in hospice care at the end of life. Palliative care is associated with reduced hospitalization costs, with savings estimates ranging from $174 to $464 per capita per day (Kelley, 2015).

Outpatient palliative care can also decrease 30-day hospital readmissions. In 2012, the national hospital 30-day readmission rate in the United States averaged 18.4% (Gerhardt, 2013). In 2011, hospitals spent $41.3 billion between January and November to treat patients readmitted within 30 days of discharge (Shinkman, 2014) consisting of:

- Approximately 1.8 million readmissions costing the Medicare program $24 billion
- 600,000 privately insured patient readmissions that totaled $8.1 billion

- 700,000 Medicaid patient readmissions that cost hospitals $7.6 billion
- 200,000 uninsured patients who were readmitted that cost hospitals $1.5 billion.

These figures are evidence of the astronomical health care costs and Medicare financial burden in the United States related to hospital readmissions. The intervention of palliative care has demonstrated reduced healthcare costs for the most medically complex patients (Meier, 2011).

## Problem/Project Purpose Statement

Although empirical evidence demonstrates significant benefits to quality of life and reduction of 30-day hospital readmissions with the intervention of palliative care, outpatient palliative care is not sufficiently available in the targeted metropolitan area (Tables 1, 2, and 3). The purpose of this practice change project is formulation of a business plan to determine the feasibility of an outpatient palliative care nurse practitioner-driven clinic.

## Literature Review

In order to provide background for the business plan, scholarly data was collected, organized, and synthesized via review of the literature. Relevant literature was retrieved using the following search engines: Pub Med, Cumulative Index of Nursing & Allied Health Literature, Google Scholar and Psychology and Behavioral Sciences databases from August 2016 through January 2017. The key words “outpatient”, “palliative care”, “adult”, “quality of life”, “30-day”, “readmission”, “nurse practitioner”, and “quality-care” were the search criteria.

### Inclusion Criteria

The integrative review of the literature related to quality of life included studies published in English that address quality of life with palliative care as an influencing factor. Multi-country studies were evaluated, although studies within the United States were preferred, as the proposed setting for the change is in the United States. Studies utilizing adults (people

over 18 years of age) as subjects were included to correlate with the patient demographic that will be served by the palliative care clinic. Studies from all levels of the hierarchy of evidence rating system were considered.

**Exclusion Criteria**

Published works not addressing quality of life of patients receiving palliative care were excluded from the literature review. Research studies not published in English were also excluded. Pediatric studies were excluded because the proposed clinic is in an English-speaking country and will provide services to people over the age of 18. Search limits of the year 2000 to present were imposed.

**Selection Criteria and Process**

Titles and abstracts of appropriate studies regarding quality of life and based on the previously mentioned criteria were reviewed. Once the final list of articles was determined, the full texts of all articles to be included were obtained and a full hand review performed. The level of evidence produced was evaluated. Studies meeting the exact criteria were difficult for two reasons: first, people experiencing a health crisis or dying people and their caregivers are a vulnerable population (Kolata, 1994), and many choose not to participate in studies. Second, quality of life is subjective and difficult to quantify (Carr, 2001). Eleven studies regarding the association of palliative care on quality of life were summarized (Appendix A).

Studies evaluating 30-day hospital readmission were evaluated for statistically significant outcome measures. To determine a potential association between palliative care and decreased 30-day hospital readmission, three studies were evaluated by Hennekens' criteria (Gordis, 2013). These three articles were placed in Table 4 for evaluation.

## Synthesis of Literature Review

The results of the eleven studies related to quality of life reviewed provide very strong evidence that there is an association between outpatient palliative care and improved quality of life in patients with life-limiting illness, as well as the quality of life of their caregivers/family members. The authors all suggest that the current available research is heterogeneous and that a need for more consistent, evidence-based research is indicated. Although there is inconsistency in research methodologies and definitions of terms, the consensus of the studies included in the integrative review is that outpatient palliative care is strongly associated with improved quality of life for patients and their caregivers.

For the potential association of palliative care decreasing hospital 30-day readmissions, three studies with statistically significant outcomes were evaluated. The Taha (2014) study produced results that were not statistically significant related to palliative care consultation being associated with decreased 30-day hospital readmission. O'Connor et al.'s (2015) and Gonzalo & Miller's (2007) studies respectively concluded that palliative care consultation was associated with reduction of 30-day hospital readmissions. O'Connor et al. (2015) determined that the palliative care consultations addressing goals of care there were associated with lower 30-day readmission rates, while those addressing symptom management were not. The potential for bias exists in all three studies (Table 5). Selection bias, recall bias, reporting bias, misclassification bias and confounding are a few inherent variables that need to be accounted for when dealing with seriously ill or dying subjects. All three studies listed numerous confounders such as diagnosis, do not resuscitate status, and dementia, which were appropriately controlled. Potential confounders that were not accounted for such as religious beliefs, family values, goals of care and hospice, and palliative care experience were identified (Table 5). Diagnosis of life-limiting illness and negative presence of dementia were appropriately controlled. The Centers for

Medicare and Medicaid have mandated that hospitals decrease 30-day readmissions with monetary fines imposed if unsuccessful (Shinkman, 2014). A priority goal of palliative care is to reduce re-hospitalizations. Two of the three studies reviewed provided evidence that palliative care is associated with decreased 30-day hospital readmissions.

**Limitations**

Quality of life with life-limiting illness is subjective, is a vulnerable population, and is therefore a challenge to standardize and quantify. The measures used to determine statistically significant outcome measures were found to be incongruent between studies in the 30-day hospital readmission studies. Selection bias in all studies is strong due to subjects not agreeing to participate or not being referred. Many of the studies evaluated the association of inpatient palliative care, not outpatient services. The majority of palliative care studies include oncology patients; however, many other life-limiting diseases benefit from palliative care services. The majority of identified studies were performed outside of the United States, and there are notable methodological differences across the studies, including varying definitions of "palliative care" and "usual care."

The three studies reviewed and evaluated regarding 30-day hospital readmission contained several confounders that were not controlled such as religious beliefs and family values related to illness and dying, patient and family goals of care, place of residence, and previous hospice/palliative care experience or exposure. Illness severity was inappropriately controlled in O'Connor et al.'s (2011) and Taha et al.'s (2014) studies. The intention of palliative care is that initiation takes place early in the chronic, life-limiting disease process. Therefore, the severity of the illness should not affect the readmission rate determined by palliative care exposure.

Seven of the top ten causes of death in the United States in 2010 were chronic diseases (CDC, 2015). The results of the studies reviewed provide very strong evidence that outpatient palliative care is associated with improving quality of life in patients with life-limiting illness, as well as the quality of life of their caregivers/family members. Despite conflicting evidence, palliative care was shown to be associated with improved quality of life, as well as reduction of 30-day hospital readmissions.

## Organizational Framework

Writing a business plan allows an organization to organize plans and form a structural framework for the direction the company will go in the next three to five years (Spragens, 2013). The United States Small Business Association's (SBA) instruction for writing a business plan is the framework for this project (U.S. Small Business Association [SBA], 2017). The components of a business plan include: Executive Summary, Company Description, Market Analysis, Organization and Management, Service Line or Product, Marketing and Sales, Funding Request/Financial Projections, and an optional Appendix.

The executive summary provides an overview of the fundamentals of the proposed venture. The company description outlines what the company is and does and why the venture is being proposed. The market analysis identifies the customers of the new venture and what they expect to receive. The organization and management description provides an organizational schematic of the company as a whole. The service line or product description explains in detail the service the new venture will provide and the needs it will meet. A marketing and sales outline demonstrates how the company will reach customers for the venture and how the venture will be implemented. Finally, the funding request and financial projections outline the funds

needed to embark on the venture and revenue streams that will be created and affected by the venture.

## Methods

A business plan was formulated utilizing the information and knowledge discovered in the literature review, as well as data from the Centers for Medicare and Medicaid (CMS) regarding fees for appropriate billing codes, financial data gathered from public information, the American Association of Nurse Practitioners (AANP), and the Medical Group Management Association (MGMA). Data regarding practice costs and revenue, as well as information regarding the specific practice into which the proposed services, was incorporated. Human Subjects IRB approval was not necessary because there was no human subject research conducted during the business plan development.

The first section of the business plan is the Executive Summary, which provides an overview of the problem requiring practice change, including supporting data from current literature of the documented needs and benefits of the intervention. In this case, the problem was consideration of the addition of palliative care outpatient services to the practice. This section provides an overview of the company's location and years in existence, highlighting its mission, vision, and values of the company.

The second section of the business plan is the Company Description. This section provides current demographics, data and incorporation information about the business. Information was derived from owner interviews and legal documents—e.g., articles of incorporation. A company organizational chart was devised for this section of the plan (Figure 1).

The Market Analysis is the third section of the business plan. The market analysis is an evaluation of the current state of the problem (i.e., outpatient palliative care services) in the affected area. This section of the business plan evaluated the metropolitan area and the availability of outpatient palliative care services in the catchment area. Information regarding health systems and organizations that offer palliative care services in the surrounding metropolitan area was obtained and organizational websites researched to determine if inpatient and/or outpatient palliative care services were offered at each. Two focus groups were held; one was made up of general public participants, the second of physicians and nurse practitioners (Addendums 2 and 3). As a part of the market analysis, a SWOT (strengths, weaknesses, opportunities, and threats) assessment was performed.

The fourth section of the business plan is the Organization and Management section. This section discusses the management of the business and the current and proposed staffing structure. An organizational chart depicting the reporting structure and duties was created. Discussion of APRN limitations secondary to state laws and physician collaboration is also included in this section.

The fifth section of the business plan is the Service Line/Marketing section. This section discusses the company's services with an emphasis on the service to fulfill the needs and expectations of target customers.

The Funding Request/Financial Projections is the final section of the business plan. In this section, funding requests along with financial projections are reviewed. Billing codes with allowable amounts are provided, as well as projections for revenue.

## Results

The Executive Summary included a synopsis of the need for outpatient palliative care as mandated by several organizations. It discussed the organization's location as well as its mission, vision, and values.

The Company Description outlined the specific demographics and information about the company. Articles of Incorporation were reviewed. The specifics of the organization's structure including specifics pertaining to each company in the organization were reviewed. The ownership, leadership, functions, and purpose of each company in the organization was outlined.

A large component of the business plan was the Market Analysis section. An overview included population data of the metropolitan area and what hospital systems were advertising outpatient palliative care on their websites (Tables 1, 2 and 3). Research performed by the Center to Advance Palliative Care (CAPC) regarding public opinion of community knowledge, understanding, and acceptance of palliative care services was reviewed. This research confirmed that consumers are fairly unaware of palliative care services, but once they understand them, they want them as part of their care when needed. Another key finding of this study was that physicians are more resistant to the use of palliative care services than are consumers. The physicians revealed that most physicians do not understand exactly what palliative care is and how and when it fits into a patient's plan of care.

After review of the CAPC public opinion research, a local focus group of fourteen women and six men was conducted at a local church. The location of the focus group was chosen because it is near the practice location and it is the church that will be providing volunteer chaplain services for the program. The questions asked of these groups are outlined in Addendum 2 and Addendum 3. The findings were consistent with CAPC public opinion research in that only two of the twenty participants understood that the purpose of palliative care

is to improve quality of life and manage symptoms for both patients and their families. Three participants had not heard of palliative care, and the remaining fifteen believed it was hospice care. After being provided with the CAPC definition of palliative care, the twenty participants agreed that outpatient palliative care is an important service and they would likely utilize it for themselves or a family member with a life-limiting chronic illness (see Addendum 1). There was some discussion as to whether the burden of another office appointment would outweigh the benefit until the two participants who understood the purpose of palliative care explained the support it provided to their family having "comfort specialists" to help them navigate the trying and emotional waters of a life-limiting illness. At the conclusion of this discussion, all 20 participants verbalized their belief that outpatient palliative care provides a great benefit and would like it to be available for themselves and their families when needed.

To build on this local focus group information, twenty healthcare providers, physicians and nurse practitioners were queried about their beliefs and understanding related to outpatient palliative care services. Five non-palliative care or hospice physicians and fifteen nurse practitioners were asked for their definition of palliative care. Two of the physicians and nine of the nurse practitioners were able to verbalize that the goal of palliative care is to alleviate symptoms and optimize quality of life for patients with chronic illness. The remaining three physicians and six nurse practitioners provided the definition of hospice. After receiving the CAPC definition of palliative care, four of the five physicians and the fifteen nurse practitioners acknowledged the benefits of outpatient palliative care and stated they would refer patients if an outpatient palliative care clinic were available (see Addendum 2). One physician reported that there would not be any benefit because he already provided this type of care. Many of the nurse

practitioners commented as to the value they believe this service will bring their patients and asked for ways to refer.

A strengths, opportunities, weaknesses, and threats (SWOT) analysis was performed to determine internal strengths and weaknesses, as well as external opportunities and threats important to consideration of the new service line implementation (Figure 2). There is strength in utilization of existing employees, the ability to integrate this service into the existing practice, the specialty experience of the nurse practitioner, the support and experience of collaborative physician, and the willingness of the local church to provide the chaplain services to facilitate implementation. Weaknesses relate to program initiation costs and restricted resources until the necessary revenue is realized. The existing practice revenue will cover start-up costs. Availability for patients to access part-time providers could be a weakness. As services grow and full-time hours are needed, this has the potential to be a weakness if the providers are unwilling to move into full-time status. Opportunities include the need for outpatient palliative care services in the Kansas City Metro area, Medicare's incentive for providers to decrease hospital readmissions, education on the purpose of palliative care for lay and professional groups, and a web and social media presence. Threats include a general lack of understanding as to what palliative care is, buy-in by the public and healthcare community, other health care providers not wanting to "share" their patients with other providers, and how providers will be reimbursed.

Strengths of adding palliative care to the existing practice with expert clinicians will leverage the financial burdens of program initiation. The need for palliative care services in the metropolitan area, along with the lack of understanding the benefits of palliative care, remain challenges.

Recognition of palliative care, which is a newer medical specialty along with the limited number of physicians who are board-certified in palliative care, was discussed earlier in this paper. Advanced practice nurses can fill this gap. A recent count of hospice and palliative care board-certified nurse practitioners and clinical nurse specialists reveal there are 1454 in the country, eleven in Kansas and ten in Missouri (HPNA, 2017). Nurse practitioners can help fill the void of needed palliative care providers at lower salaries than physicians.

The Organization and Management section of the business plan investigated the current staffing and management structure of the organization and how the addition of palliative care service would be integrated. Challenges facing APRNs in providing care in states without full practice authority were reviewed, along with the IOM recommendations previously discussed in this paper and the high quality of care historically provided by nurse practitioners. Twenty-two states and the District of Columbia have passed legislation granting nurse practitioners full practice authority to evaluate patients, diagnose, order, and interpret diagnostic tests, and initiate and manage treatments, including prescriptive authority under the exclusive licensure authority of the nursing boards of the states (AANP, 2017), but Kansas does not. The American Academy of Nurse Practitioners (AANP) represents over 205,000 nurse practitioners, and their statistics show that in 2012, more than 900 million healthcare visits were performed by nurse practitioners, and that number is expected to grow significantly in the years to come (AANP, 2015).

Currently NPs in Kansas are licensed as APRNs, and they may evaluate and manage patients if they have a collaborative practice agreement with a physician licensed in the state of Kansas (Kansas State Board of Nursing, 2016). Johnson County Palliative Care will be managed and care provided by the hospice and palliative care board-certified nurse practitioner. The

practice physician will be in collaborative agreement with the nurse practitioner to meet state rules and regulations for APRN practice. The physician will be available to see patients as well.

Nursing and administrative staff is already in place within the organization. Members of a palliative care team generally include a provider, nurse, social worker, and chaplain. A master's prepared social worker (MSW) will be employed on an as-needed basis until the growth of the program is able to support a part- or full-time addition. A local church has agreed to supply chaplain services as a part of their ministry to the community. An organizational chart depicting the reporting structure and duties within the organization was created.

In the Service Line or Product and Marketing section of the business plan, the integrative review performed and discussed previously in this paper was summarized in this section along with the CAPC Public Opinion Research, and a marketing plan was outlined accordingly. Integrated messaging includes the CAPC definition of palliative care, as well as services offered:

- Symptom Management – reduce physical suffering from pain, fatigue, breathlessness, nausea, vomiting, and other physical symptoms;
- Help with Medical Decision-Making – assist with deciphering medical information, clarify goals of care as they relate to the patients' and families' goals, values, and beliefs;
- Emotional and Coping Support – address fear, anxiety, depression and grief;
- Spiritual and Cultural Support – honor and support cultural values.

Marketing this service will begin with the nurse practitioner-providing insurance companies such as Blue Cross and Blue Shield of Kansas City and United Healthcare with information about the services. Information will be forwarded to the insurance company medical directors and nurse case managers, outlining the ways in which outpatient palliative care services

can assist them in better serving their subscribers. The clinic is listed on the National Palliative Care website. The nurse practitioner is listed in the "find a provider" section of the Hospice and Palliative Nurses Association's website. A page of the practice website is dedicated to Johnson County Palliative care, with information and referral options (http://lookgoodfeelgoodbehealthy .com/johnson-county-palliative-care/). Presentations will be made by the palliative care nurse practitioner to local nurse practitioner groups. Local hospitals' medical staff offices will be provided with information on how to make referrals. Once patients are referred and seen, prompt communication with the referring provider will be a key method to ensure continued referrals. Office staff will be trained on palliative care and what the services will provide to enable informed conversations.

For the Funding/Financial section of the business plan, there was no funding request needed secondary to the addition of this service to an existing practice. Financial projections were made based on projected revenue and costs. Cost for introduction of the new service line is minimal because it is being added to an existing practice within the current staffing model. Marketing costs will be roughly $500 and will include paper, ink and the time of the nurse practitioner conducting the presentations. The business has the capacity to add another provider room five days a week.

Providers will be paid on a contract basis based on a percent of collections. Therefore no additional provider salary, benefit or tax expenditure is anticipated. It is projected that 80% of the revenue will come from third-party payors. When billing third-party payors, Current Procedural Terminology (CPT) codes are numeric codes used to describe all medical visits, tests, procedures performed by healthcare providers. CPT codes are submitted to third-party payors to request reimbursement for services performed by healthcare providers (Practice Management

Corporation, 2016). These codes can be based on time spent or level of medical decision-making. Insurance companies with the highest participation within the practice, as well as Medicare price file queries of new and established office evaluation and management codes, were obtained. The averages for the codes were placed into Tables 6 and 7. New CPT codes for advanced care planning are listed with allowable reimbursement in Table 8.

Palliative care visits require more time than the average 15-minute doctor visit due to the nature of these complex visits. Advanced care planning, goal realization and setting, caregiver support and evaluation, and patient physical, emotional, mental, and spiritual health are areas addressed. It is projected that in the office setting, when functioning at capacity, 8-16 patients a day would be seen with an average CPT bill of a 99214, grossing $800-$1600 per day. Home visits for patients unable to come to the office because of the severity of their illness are available and billed/paid with the home visit CPT codes. Due to the time required for travel between patients, home visits decrease the number of patients seen secondary to time for minimally increased reimbursement. It is expected this service line will be profitable within 12 months. Cash-pay telehealth visits for patients who are either out of town or too ill to travel to the office to be seen are planned as a future service. The average telehealth visit is $50 and is not reimbursed by insurance or Medicare in the Kansas City area.

## Discussion

The Small Business Association's steps on the *How to Write a Business* Plan (SBA, 2017) provided a rich framework for the writing of the business plan. Each step provided guidance and insight to a different aspect of the organization, as well as the potential risks and benefits to adding palliative care service to the organization. The addition of the focus group and queries of medical professionals in the area added live thoughts and interactions about what

palliative care is and if the addition of an outpatient palliative care service in the area would be viewed as beneficial. Formulating financial projections based on potential visit reimbursement was very helpful in determining if the addition of the service would be feasible. Future research is needed in the area of palliative care, specifically outpatient and primary palliative care. Randomized clinical trials would be highly valuable along with retrospective studies related to financial implications for patients and the healthcare system with the addition of palliative care.

The next steps for realizing this service entail marketing this program and initiation of patient visits. A strong marketing plan is imperative for growing a palliative program (CAPC, 2017). Marketing to insurance companies as previously discussed will be very important. Just as important is a consumer-focused social marketing platform (Youngner & Arnold, 2016). This begins with an in-depth understanding of the clientele to be served (CAPS, 2017). Because of the confusing messages historically presented to the public regarding palliative care services, and consumer as well as healthcare professional lack of understanding regarding palliative care, there must be a consistent message delivered defining palliative care as specialized care that focuses on quality of life provided at any point in the trajectory of a serious illness (CAPC, 2017). In this day and age, almost all marketing begins with a web and social medial presence. Barreto & Whitehair (2017) claim that social media has become an instinctual part of daily routine. Healthcare providers should take strategic advantage of the abundant social media platforms available to engage the public and market their services (Barreto & Whitehair, 2017).

Palliative care nurse practitioners broaden access to palliative care and provide value that exceeds their specialized and expanded knowledge, evidence-based practice, and psychosocial-spiritual care (HPNA, 2017). The available evidence reviewed and included in the business plan (Addendum 4) supports the feasibility of a nurse practitioner outpatient palliative care service to

provide high-quality, cost-effective care associated with decreased 30-day hospital readmission and improved quality of life. The plan is to introduce the outpatient palliative care service line in the fall of 2017.

Figure 1: Organizational Chart

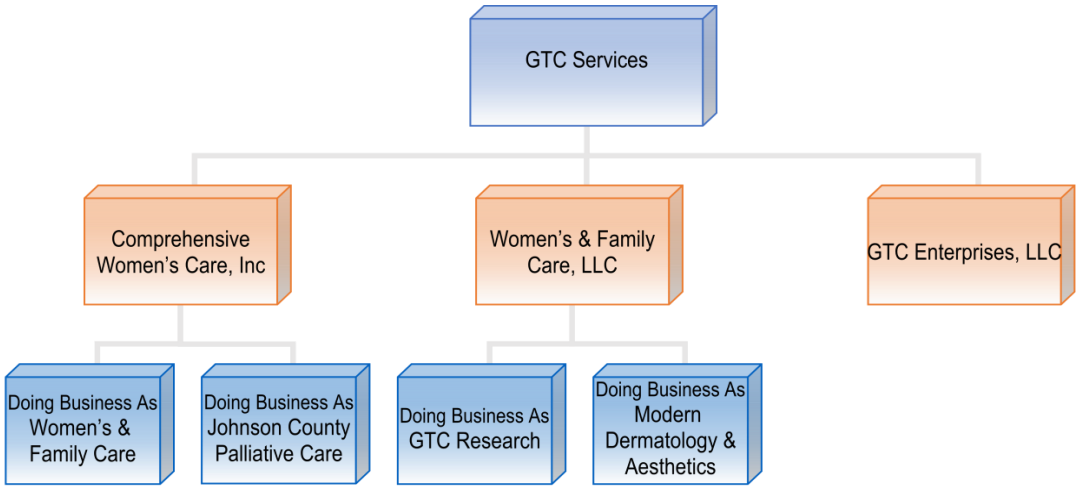

Figure 2: SWOT Analysis

Table 1

*Missouri Hospital Palliative Care Services Present on Hospital Website January 31, 2017*

| **Missouri Hospitals** | Website Indicates Inpatient Palliative Care Services Available | Website Indicates Outpatient Palliative Care Services Available | Comments |
|---|---|---|---|
| Centerpoint | No | No | System Website |
| Liberty | Yes | No | |
| North Kansas City | Yes | Yes | Have a palliative care RN |
| Research | No | No | System Website |
| Saint Luke's Hospital | Yes | No (Palliative Care Home Health Available) | System Website |
| Saint Luke's East | No | No | System Website |
| Saint Luke's North | No | No | System Website |
| Saint Luke's Smithville | No | No | System Website |
| St Joseph | No (Bereavement services listed) | No | System Website |
| St Mary | No | No | System Website |
| Truman Medical Center | No (The do have palliative care services) | No | System Website |
| Truman Medical Center Lakewood | No | No | System Website |
| VA Kansas City | Yes | No | |

Table 2

*Kansas Hospital Palliative Care Services Present on Hospital Website January 31, 2017*

| **Kansas Hospitals** | Website Indicates Inpatient Palliative Care Services Available | Website Indicates Outpatient Palliative Care Services Available | Comments |
|---|---|---|---|
| Menorah | No | No | System Website |
| Olathe | No (They do have palliative care) | No | |
| Overland Park Regional Medical Center | No | No | System Website |
| Providence | No | No | System Website |
| Saint Luke's South | No | No | System Website |
| Shawnee Mission Medical Center | Yes | No | |
| University of Kansas Medical Center | Yes | No | |

Table 3

*Non-Hospital Based Kansas City Area Palliative Care Services January 31, 2017*

| | Services in Kansas | Services in Missouri | Comments |
|---|---|---|---|
| Crossroads Hospice and Palliative Care | Yes | Yes | Home Based |
| Kansas City Hospice and Palliative Care | Yes | Yes | Home Based |

Table 4

*Hennekens Criteria*

| | Study 1 | Study 2 | Study 3 |
|---|---|---|---|
| Chance | 95% CI (0.27-0.48)<br>Statistically Significant | 95% CI (0.45-0.50)<br>Statistically Significant | 95% CI (0.824-4.299)<br>Not Statistically Significant |
| Bias | Recall Bias<br>Reporting Bias<br>Misclassification Bias<br>Selection Bias<br>Confounding | Recall Bias<br>Reporting Bias<br>Misclassification Bias<br>Selection Bias<br>Confounding | Recall Bias<br>Reporting Bias<br>Misclassification Bias<br>Selection Bias<br>Confounding |
| Confounding | Diagnosis-appropriately controlled<br>DNR Status-not controlled<br>Self-Assessment of Health-appropriately controlled<br>Positive Depression Screen-appropriately controlled<br>Intact Cognition/Negative Dementia-appropriately controlled<br>Religious Beliefs-not controlled<br>Family Values-not controlled<br>Goals of Care-not controlled<br>Previous Hospice/Palliative Care Experience-not controlled<br>Place of Residence-not controlled<br>Illness Severity-inappropriately controlled | Diagnosis-appropriately controlled<br>DNR Status-appropriately controlled<br>Self-Assessment of Health-not controlled<br>Positive Depression Screen-not controlled<br>Intact Cognition/Negative Dementia-appropriately controlled<br>Religious Beliefs-not controlled<br>Family Values-not controlled<br>Goals of Care-not controlled<br>Previous Hospice/Palliative Care Experience-not controlled<br>Place of Residence-appropriately controlled<br>Illness Severity-not controlled | Diagnosis-appropriately controlled<br>DNR Status-appropriately controlled<br>Self-Assessment of Health-not controlled<br>Positive Depression Screen-not controlled<br>Intact Cognition/Negative Dementia-appropriately controlled<br>Religious Beliefs-not controlled<br>Family Values-not controlled<br>Goals of Care-not controlled<br>Previous Hospice/Palliative Care Experience-not controlled<br>Place of Residence-not controlled<br>Illness Severity-inappropriately controlled |
| Strength of Association | 0.36<br>Strong | 0.47<br>Strong | 1.882<br>Moderate |
| Biologic Plausibility | N/A | N/A | N/A |
| Consistency | No | No | No |
| Temporality | Yes | Yes | Yes |
| Dose Response | N/A | N/A | N/A |

Table 5

*Article Summarization Table*

| | Study 1 | Study 2 | Study 3 |
|---|---|---|---|
| Reference | O'Connor, N., Moyer, M., Behta, M., & Casarett, D. (2015). The impact of inpatient palliative care consultations on 30-day hospital readmissions. *Journal of Palliative Medicine.* 16(X). 1-6 | Gozalo, P., & Miller, S. (2007). Hospice enrollment and evaluation of its causal effect on hospitalization of dying nursing home patients. *Predictors of Mortality.* Health Research and Educational Trust. | Taha, M., Pal, A., Mahnken, J., Rigler, S. (2014, March 5). Derivation and validation of a formula to estimate risk for 30-day readmission in medical patients. *International Journal for Quality in Health Care.* 6(3). 271-277 |
| Study Design | Retrospective cohort study | Retrospective cohort study | Retrospective cohort study |
| Study Population | All live discharges (n=23, 524) between August 2013 and November 2014 | Nursing home residents in 5 states who died between 1995-1997 (n=14,615). | Inpatients aged 18 and older on general internal medicine services (n=858) |
| Exposure | Palliative Care | Palliative Care Hospice | Palliative Care |
| How was exposure measured? | Hospital Electronic Medical Record System was used to identify all live discharges between 8/2013 and 11/2014. | Medicare claims identified hospice enrollment and hospitalizations. | Electronic Medical Record Review |
| Outcome | 30-day Readmission rate | 30-day Readmission rate | 30-day Readmission rate |
| How was outcome measured? | Electronic Medical Record | A file linking MDS assessments to Medicare Claims and denominator files, nursing home files (OSCAR), hospice provider of service files and the area resource file was constructed. | Electronic Medical Record |

Table 6

*Reimbursement for Evaluation and Management Codes for Commercial Carriers*

| E&M | Fee Schedule |
|---|---|
| 99201 | 40.78 |
| 99211 | 21.27 |
| 99202 | 71.17 |
| 99212 | 41.59 |
| 99203 | 104.83 |
| 99213 | 63.97 |
| 99204 | 154.13 |
| 99214 | 100.09 |
| 99205 | 195.02 |
| 99215 | 141.86 |

Table 7

*Medicare Reimbursement for Evaluation and Management Codes*

| E&M | Fee Schedule |
|---|---|
| 99201 | 41.48 |
| 99211 | 19.06 |
| 99202 | 71.02 |
| 99212 | 41.26 |
| 99203 | 102.58 |
| 99213 | 69.62 |
| 99204 | 156.71 |
| 99214 | 102.67 |
| 99205 | 197.56 |
| 99215 | 138.41 |

Table 8

*CMS Advanced Care Planning Codes Reimbursement*

| E&M | Fee Schedule |
|---|---|
| 99497 (30 minutes) | 79.33 |
| 99498 (additional 30 minutes) | 69.66 |

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Appendix A

*Literature Review*

| Citation (author/ year) | Design | Level of Evidence | Sample/ Setting | Data Collection | Key Findings | Limitations | Other Important Notes/ Information |
|---|---|---|---|---|---|---|---|
| Beernaert, K., et al. 2015 | Qualitative Interview | VI | 18 face-to-face, semi-structured, qualitative interviews with subjects with cancer, COPD, Heart Failure and dementia at different phases of the illness trajectory from March 2012 to June 2012 in Flanders, Belgium | Consolidated Criteria for Reporting Qualitative Research, qualitative data software, Independently coded, discussed and agreed upon. Codes categorized into core domains of palliative care indentified in previous research. | Early Palliative Care heightens quality of life. Multidisciplinary palliative approach is ideally suited for people with life-limiting illness | Purposefully heterogeneous, recall bias, psychological post hoc adjustments from prior experiences, subject participation to make a point is possible, small sample, semi-structured interviews, performed in Belgium. | Objective: to determine elf-reported benefits of palliative care. |
| Davis, M., et al. 2015 | Systematic Review | I | 28 Randomized Control Trials and 7 Systematic Reviews | Electronic searches of PUBMED followed by hand searches. | Multiple studies have demonstrated several benefits to early outpatient palliative care for | No quantifications of findings, just description due to infrequent power calculations in studies. | Objective: To examine the evidence for the benefits of outpatient and home palliative care. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | newly diagnosed metastatic cancer.<br><br>Several studies demonstrate that symptoms and quality of life are not improved. | Did not declare method of study critique.<br><br>Within studies reviewed: Inconsistent definitions of "early" palliative care and "usual" care, Study designs and procedures inconsistent and flawed, heterogeneous populations in many studies and imbalances between randomly-allocated occurred frequently. 40% attrition. Blinding of individuals assessing outcomes not mentioned. Inattention to analysis and detail, | Researchers state that while multiple studies have shown some benefit to palliative care, better designed and executed studies are needed. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | Assumption same model of care efficacy across diseases<br><br>unsubstantiated. | |
| Devi, P.<br><br>2011 | Expert Opinion | VII | Review of a few clinical trials with expert opinion | Review and summary of trials with expert opinion | Not a full systematic review, cohort retrospective study or randomized trial. | Expert opinion without much scholarly supporting documentation. | Objective: To highlight the benefits of palliative care and the importance of early initiation. |
| Finlay, I, Pratheepawanit, N. & Salek, M. 2003 | Prospective cohort study | IV | 219 patients attending the palliative medicine outpatient clinic at a regional oncology center over a 2 year period. Does not state where. | Revised McGill Quality-of-Life Questionnaire | Improvement in reported quality-of-life ($p$=0.003), increased physical well-being ($p$=0.004), psychological domain ($p$=0.01) | Very little information about the study obtainable. Just results are posted. No design, method, analysis, etc. | Objective: To evaluate the efficacy of an outpatient palliative care clinic.<br><br>The results of this study were found in three different journals and in all three, it is listed under a "Correspondence" section. Would like |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | to see the entire study publication. |
| Groh, G., et al.<br><br>2013 | Prospective nonrandomized, | VI | 100 patients treated at the Interdisciplinary Centre for Palliative Medicine at the University of Munich, Germany between April and November 2011. | Patients: 2 patient questionnaires, McGill Quality-of-Life Questionnaire, Minimal Documentation System for Palliative Medicine, Palliative Outcome Scale.<br><br>Caregivers: 2 questionnaires, Quality of Life in Life Threatening Illness – Family Care Version, Hospital Anxiety and Depression Scale | Palliative Home Care provided a pivotal contribution to the quality of care in a patient's palliative and dying phase. The team significantly improved the perceived quality of life of patients ($p$=0.05) and caregivers ($p$=0.001) and lowered the caregivers' burden of care as well as anxiety and depression levels | Interviewer was unblended<br><br>Limited generalizability due to small number conducted at only one site and in a different country.<br><br>Participant responses may have been influenced by social desirability | Objective: To evaluate the effectiveness of one of the first Specialized Outpatient Paliative Care teams at the Munich University Hospital. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | ($p$=0.001). | | |
| Higginson, I., et al.<br><br>2003 | Systematic Review | I | Grade II or II Studies that compared palliative care or hospice teams. Study populations were patients with a progressive, life-limiting illness and their care givers. Usual care was routine community and general hospital/oncology services | Meta Regression and Meta Analysis | Quantitative benefit to patients from the intervention of palliative care teams Small benefit to patients pain (OR: 0.38, 95% CI: 0.23-0.64), other symptoms (OR: 0.51, CI: 0.30-0.88) | Inconsistent data and methods within studies. | Objective: To quantitatively demonstrate benefit from palliative and hospice care teams |
| Hui, D., et al. 2014 | Retrospective cohort study.<br><br>Secondary analysis of a study examining palliative care referral pattern at | IV | 366 adult patients residing in the Houston area who died of advanced cancer between 9/1/2009 and 2/28/2010 and had a | Chart review via institutional database | Patients referred to outpatient palliative care had improved end-of-life care compared to inpatient palliative care including | All treated in the same hospital system | Objective: To compare patients referred as outpatients to palliative care services vs patients referred as inpatient nnts and its effect on quality of |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | the institution | | palliative care consultation were included. | | improved symptom management and thus quality of life.<br><br>Early palliative care intervention >3 months before death, resulted in a lower composite aggressive end-of-life score, pain and depression were detected and managed better. | | life. |
| Miettinen, T., Alaviuhkola, H. & Pietila, A. 2001 | Phenomenography | VII | 9 family members living is Finland in the same local health center area | Theme centered interview | Individual palliative care was essential in increasing the dying patients' quality-of- | Very small number, subjective interviewing, self report and interview bias, | Objective: To determine, according to family members, which elements of palliative |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | life | | care are most valuable and important.<br><br>The insight gained from the answers to the questions provides much data otherwise not obtained. |
| Rabow, M., et al.<br><br>2004 | Prospective, cluster randomized (coin-flip method) Control Trial | II | 90 patients with CHF, COPD or cancer, in a general medicine practice at an urban academic medical center randomized 50 to the intervention group and 40 to the control group. | Rapid Disability Rating Scale, the Brief Pain Inventory and CES-D for depression scales, at completion a semi-structured exit interview to assess perceptions of acceptability and efficacy of the Comprehensive Care Team | Consultation by palliative medicine team lead to improved patient outcomes in dyspnea ($p$=0.01), anxiety ($p$=0.05), spiritual well-being ($p$=0.007) and sleep quality ($p$=0.05). Consultation failed to improve pain or depression. | Particular patients were not randomized and some refused participation. More women were in intervention group. Exit interviews may have been limited by acquiescence bias. Small sample. May not be generalizable. | Objective: To evaluate the impact of outpatient palliative care on outcomes if patients continue to pursue treatment for their underlying disease. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | interventions | | | |
| Rabow, M., et al.<br><br>2013 | Systematic Review | I | 4 peer-reviewed outcomes research including both observational and controlled trials of nonhospice outpatient palliative care services | PRISMA, studies in English, randomized control trials, studies reporting the impact of palliative care on quality of care, cost of care and patient/care giver experience including quality of life and symptom burden. | Improved symptom management and quality of life were consistently demonstrated at 1 week, 1 month and 12 week follow ups. Available evidence supports the expansion of palliative care services to all patients with serious illness and full integration of palliative care services across the continuum of care. | Inconsistent research methods, most studies are adults with cancer, non-uniform outcome measures, mostly observational data, limited research | Objective: To review and assess the evidence of the impact of outpatient palliative care. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Rabow, M., et al.<br><br>2003 | Single Armed trial. Substudy of Rabow, M., et al. 2013 trial | IV | 50 patients with CHF, COPD or cancer, in a general medicine practice at an urban academic medical center. | Rapid Disability Rating Scale, the Brief Pain Inventory and CES-D for depression scales, at completion a semi-structured exit interview to assess perceptions of acceptability and efficacy of the Comprehensive Care Team interventions | Outpatient palliative care consultation offered simultaneously with usual primary care is acceptable and efficacious. 100% reported feeling "cared for" and "valued". 80% reported an increased sense of connection with PCP and 71.4% increased sense of connection with family members | Small number, role of ethnicity, uncontrolled data based on patient report with data collected by staff | Objective: To determine if patients pursuing treatment for their underlying disease feel they benefit from early palliative care.<br><br>Substudy of the Rabow, M. et al 2013 study |

Appendix B: Community Focus Group Information

Focus group was held at a local church prior to a CPR class. There were 20 participants ages 22-67. Eleven were female and nine male. Participants were asked the following questions:

- Please tell me what you know about palliative care
- What is your experience with palliative care
- After being provided the CAPC definition of palliative care: what are your thoughts about palliative care?
- Would you want the option of outpatient palliative care for yourself or your family members in addition to traditional care when needed?

Appendix C: Physician/Nurse Practitioner Questions Information

Five physicians and fifteen nurse practitioners were asked the following questions:

- What is your definition of palliative care?
- Do you see a benefit to outpatient palliative care for you and your patients?
- Do you routinely refer patients to outpatient palliative care?
- After receiving the CAPC definition of palliative care: Does this change your opinions of palliative care?
- Do you see value in a local outpatient palliative care clinic?
- Would you refer patients to a local outpatient palliative care clinic?

Appendix D


JOHNSON COUNTY
PALLIATIVE CARE
21624 Midland Drive
Shawnee, KS 66218
(913) 643-0075
WWW.LOOKGOODFEELGOODBEHEALTHY.COM

**Johnson County Palliative Care**
**Business Plan Proposal**

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EXECUTIVE SUMMARY

Although empirical evidence demonstrates significant benefits to quality of life and reduction of 30-day hospital readmissions with the intervention of palliative care, outpatient palliative care is not sufficiently available in the Kansas City metropolitan area. In response to Center for the Advancement of Palliative Care (CAPC, 2011) public opinion research, the following definition was developed and encouraged to be used to increase public awareness, understanding and acceptance of palliative care:

> *Palliative care is specialized medical care for people with serious illness. This type of care is focused on providing patients with relief from the symptoms, pain and stress of a serious illness – whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurse practitioners, nurses and other specialists who work with a patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.*

The 2008 National Priorities Partnership (NPP) report identifies palliative care as one of six priority areas that would significantly improve the quality of health care in America (Meier, 2011). Kavalieratos, et al (2016) and Ranganathan, et al (2013) provide evidence that patients and families who receive palliative care services have shown improvements in quality-of-life and a reduction in 30-day hospital readmissions respectively.

Palliative care nurse practitioners broaden access to palliative care services and provide value in their expanded and knowledge. This includes symptom management, advanced care-planning and psychosocial-spiritual care (Hospice and Palliative Nurse Association [HPNA], 2017). Evidence reviewed, included in this business plan, supports the feasibility of a nurse practitioner outpatient palliative care service providing high quality, cost effective care as a factor associated with decreased 30-day hospital

readmission, and improved quality of life to patients and their families/care givers in and around the Kansas City area.

GTC Services, located in Western Shawnee, KS, Johnson County, is a group of companies in business for 15 years. GTC provides services to residents of the greater metropolitan Kansas City area. The addition of *Johnson County Palliative Care* will provide yet another service line for the practice of a much needed specialized health care service to the community. According to founding members, GTC Services' mission is to:

> Partner with patients throughout all the stages of their lives to meet and achieve their healthcare goals and to help them *look good, feel good and be healthy*!

Johnson County Palliative Care's Vision is:

> To be an outpatient palliative care leader in the community by delivering individualized quality care fostered by clinical excellence,

The Mission of Johnson County Palliative Care is:

> Empowering our community to live with faith, hope and resilience throughout an illness journey by providing patient and family centered care that enhances lives through compassionate, cost effective, quality care.

Johnson County Palliative Care's Values of Faith:

> **F**aith
>
> Faith in God and each other to work together to make right choices for our patients, families, practice and community consistent with their goals, values and beliefs.
>
> **A**uthentic
>
> To always strive for authentic, confident, compassionate care as we work individually and collectively to best meet the needs of those with whom we work and serve.
>
> **I**nterdependence

We are interdependent and connected with God, each other and all those we have the privilege to serve.

**T**herapeutic

To always be mindful of the therapeutic options and treatments to best meet the needs of the patient and family based on their belief, values and goals. These may include medical, support, spiritual or complimentary interventions to reach the desirable benefit.

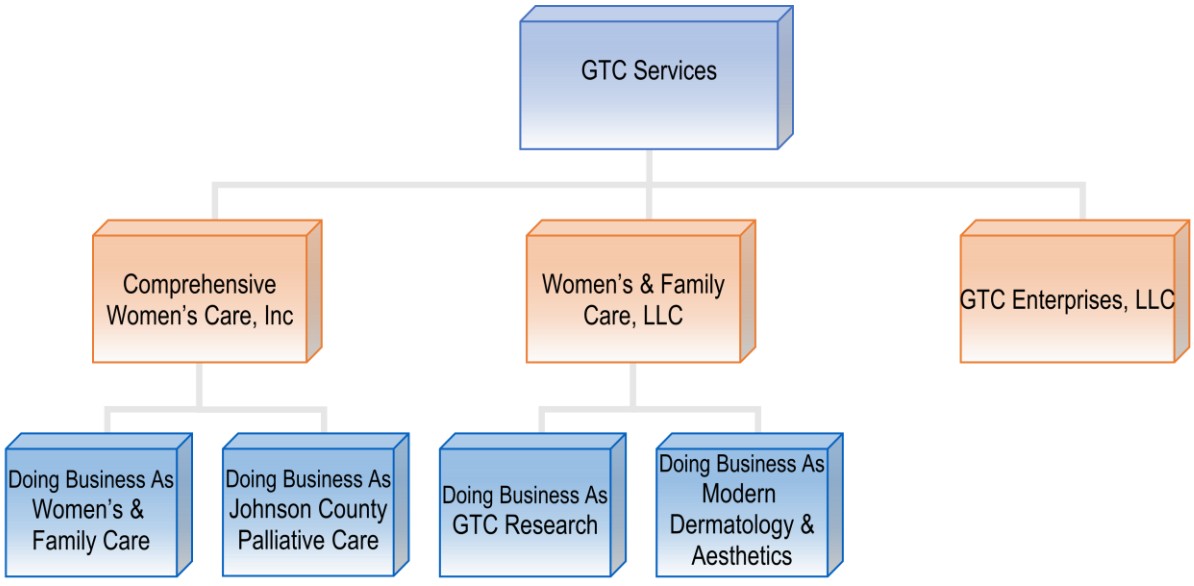
**H**onesty

The courage to always honestly speak the truth in love, and to model behavior consistent with our mission and values.

Company Description

GTC Services is made up of three companies focused on the provision of healthcare and is owned by a physician and nurse practitioner. The first, Comprehensive Women's Care, Inc. is a C-Corporation formed in 2003, initially as an OB/GYN practice. It now functions publically as Women's and Family Care, a multi-specialty medical practice. The Comprehensive Women's Care, Inc corporate tax identification number is utilized in participation with insurance companies, and Medicaid/Medicare contracts. Johnson County Palliative Care will function under the Comprehensive Women's Care, Inc. arm of the business.

Women's & Family Care, is a limited liability corporation (LLC) with the physician as a 51% member and nurse practitioner 49% member. As such, in the state of Kansas, it has health care entity status and provides professional liability insurance coverage for all employees. All staff performing medical services for any of the companies is leased from Women's & Family Care to afford this coverage. Women's & Family Care, LLC is cash only company, meaning it does not accept insurance payments. Two businesses operate under Women's & Family Care, LLC: GTC Research: a clinical trial practice; and Modern Dermatology & Aesthetics: a dermatology aesthetic practice. The third GTC Services Company is GTC Enterprises, LLC, a real estate limited liability corporation that owns the physical space that is leased to the above companies, providing another layer of financial protection to the owners and employees.



MARKET ANALYSIS

The Kansas City (KC) metropolitan area is a 15 county area in both Kansas and Missouri. The KC metro area has a population of 2.34 million people (World Population Review, 2017). Johnson County, KS, makes up the southwestern area. There is limited availability of palliative care services in the KC metro as noted in Tables 1, 2 and 3 below.

Table 1: Missouri Hospital Palliative Care Services Present on Hospital Websites January 31, 2017

| **Missouri Hospitals** | Website Indicates Inpatient Palliative Care Services Available | Website Indicates Outpatient Palliative Care Services Available | Comments |
|---|---|---|---|
| Centerpoint | No | No | Hospital found on health system website |
| Liberty | Yes | No | |
| North Kansas City | Yes | Yes | Have a palliative care RN |
| Research | No | No | Hospital found on health system website |
| Saint Luke's Hospital | Yes | No | Hospital found on health system website. Palliative Care Home Health Available. |
| Saint Luke's East | No | No | Hospital found on health system website |
| Saint Luke's North | No | No | Hospital found on health system website |
| Saint Luke's Smithville | No | No | Hospital found on health system website |
| St Joseph | No | No | Hospital found on health system website. |

| | | | |
|---|---|---|---|
| | | | Bereavement services listed. |
| St Mary | No | No | Hospital found on health system website |
| Truman Medical Center | No | No | Hospital found on health system website. They do have palliative care services though not listed on the website. |
| Truman Medical Center Lakewood | No | No | Hospital found on health system website |
| VA Kansas City | Yes | No | |

Table 2: Kansas Hospital Palliative Care Services Present on Hospital Websites January 31, 2017

| **Kansas Hospitals** | Website Indicates Inpatient Palliative Care Services Available | Website Indicates Outpatient Palliative Care Services Available | Comments |
|---|---|---|---|
| Menorah | No | No | Hospital found on health system website |
| Olathe | No | No | They do have palliative care services though not listed on the website |
| Overland Park Regional Medical Center | No | No | Hospital found on health system website |
| Providence | No | No | Hospital found on health system website |
| Saint Luke's South | No | No | Hospital found on health system website |
| Shawnee Mission Medical Center | Yes | No | |

| | | | |
|---|---|---|---|
| University of Kansas Medical Center | Yes | No | New outpatient palliative care clinic. |

Table 3: Non-Hospital Based Kansas City Area Palliative Care Services From January 31, 2017

| | Services in Kansas | Services in Missouri | Comments |
|---|---|---|---|
| Crossroads Hospice and Palliative Care | Yes | Yes | Home Based |
| Kansas City Hospice and Palliative Care | Yes | Yes | Home Based |

Palliative care is an emerging specialty. In 2006 the American Board of Hospice and Palliative Medicine achieved recognition for the subspecialty of Hospice and Palliative Medicine by the American Board of Medical Specialties (American Academy of Hospice and Palliative Medicine, 2017). As of 2015, there were only 6,500 physicians board certified in hospice and palliative care in the United States (The EDITORS, June, 2015) while the need is estimated to be 17,000. A recent count of board certified nurse practitioners and clinical nurse specialists reveal there are 1454 in the country, eleven in Kansas and ten in Missouri (HPNA, 2017). Nurse practitioners can help fill the void of needed palliative care providers at a lower salary cost than physicians.

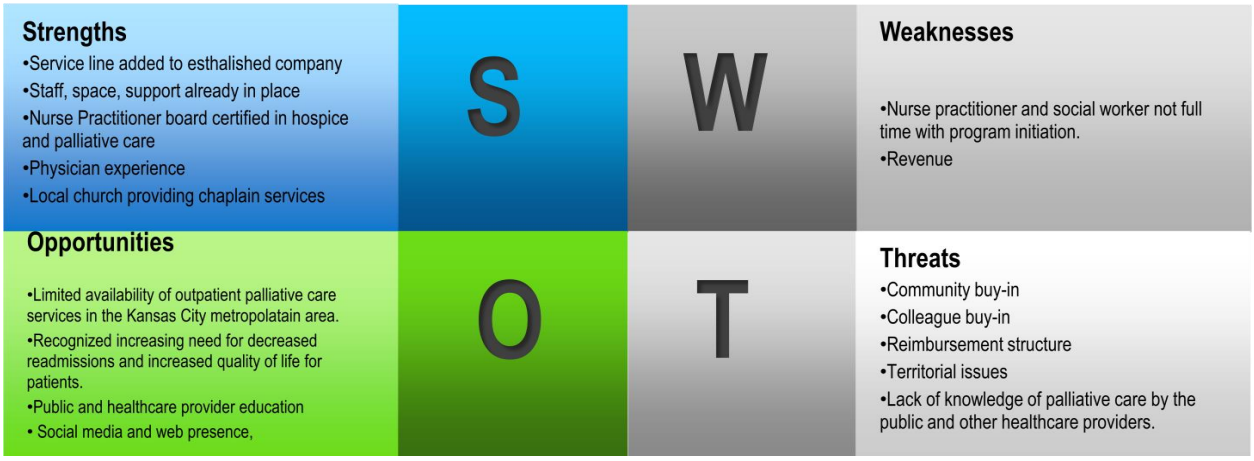
The Center to Advance Palliative Care (CAPC) performed research on public opinion of community knowledge, understanding, and acceptance of palliative care services in 2011. This research confirmed that consumers are fairly unaware of palliative care services, but once they understand it, they want it as part of their care when it is needed. Another key finding of this study was that physicians are more resistant to the use of palliative care services than are consumers. The physicians revealed most do not understand exactly what palliative care is and how and when it fits into a patient's plan of care.

A local focus group of fourteen women and six men was performed in a local church prior to a CPR class in April, 2017. Participants were asked to explain what they know about palliative care and what their experience was with palliative care. They were then read the CAPC definition of palliative care and asked what their thoughts were about this kind of service and if they felt they would like the option of palliative care when needed for themselves or their family members. The findings were consistent with the CAPC public opinion research in that only two of the twenty participants understood that the purpose of palliative care is to improve quality of life and manage symptoms for patients and their family. Three participants had never heard of palliative care and the remaining fifteen believed it was hospice care. After being provided the CAPC definition of palliative care, the twenty participants agreed that outpatient palliative care is an important service and they would likely utilize it for themselves or a family member with a life-limiting chronic illness (see Addendum 1). The two who understood the purpose of palliative care explained the support it provided to their family having "comfort specialists" to help them navigate the trying and emotional waters of life limiting illness.

Five physicians and fifteen nurse practitioners not currently involved in the provision of formal palliative or hospice care were asked for their definition of palliative care. These providers were asked what their definition of palliative care is and asked if they referred patients to palliative care and/or they saw a benefit to palliative care services. After receiving the CAPC definition of palliative care, they were asked if their understanding or opinion about palliative care services had changed. They were asked if they see value in outpatient palliative care services and if they would refer patients to a local outpatient palliative care clinic. Two of the physicians and nine of the nurse practitioners were able to verbalize that goal of palliative care is to alleviate symptoms and optimize quality of life for patients with chronic illness. The remaining three physicians and six nurse practitioners provided the definition of hospice: care for people with a prognosis of 6 months or less. After receiving the CAPC definition of palliative care, four of the five physicians and all fifteen nurse practitioners acknowledged the value of outpatient palliative care for their

patients, family and themselves as providers, and stated they would refer patients to an outpatient palliative care clinic were one available (see Addendum 2). The single physician who saw no benefit commented that he already does this with his patients on his own. Many of the nurse practitioners commented as to the value they believe this service will bring their patients and asked for instructions as to how to complete the referral process.

A strengths, opportunities, weaknesses and threats (SWOT) analysis was performed to determine internal strengths and weaknesses, as well as external opportunities and threats important for consideration of the new service line implementation. There are many strengths in this space; existing employees, ability to integrate the service into the existing practice, specialty experience of the nurse practitioner, support and experience of collaborative physician, and the willingness of the local church to provide chaplain services to facilitate implementation. Part-time employment of the nurse practitioner and social worker is a strength that increases provider satisfaction as the team social worker prefers part-time employment. Weaknesses relate to program initiation costs and restricted resources until necessary revenue is realized. To facilitate start-up, initial expenses will be covered by the existing practice revenue. Patient's limited access to only part time providers is a potential weakness and as the service grows increased provider coverage and full-time hours are needed, this has the potential to be a weakness if the providers are unwilling to move into full-time status. Opportunities include: the need for outpatient palliative care services in the Kansas City Metro area, Medicare's incentive for providers to decrease hospital readmissions, education provision about palliative care to local nurse practitioner groups and to the community and the strategic use of the abundant social media platforms available to engage the public and market this service is an important opportunity (Barreto & Whitehair, 2017). Threats include general lack of understanding as to what palliative care is, buy-in by the public and healthcare community, and third party payors. Health care providers may feel threatened and choose not to "share" their patients with another provider. Methodology of service reimbursement is also a threat.




Strengths and opportunities will be leveraged to overcome weaknesses and threats by adding palliative care services to the existing practice minimizes start-up and overhead costs and utilization of contract employed specialists in this field.

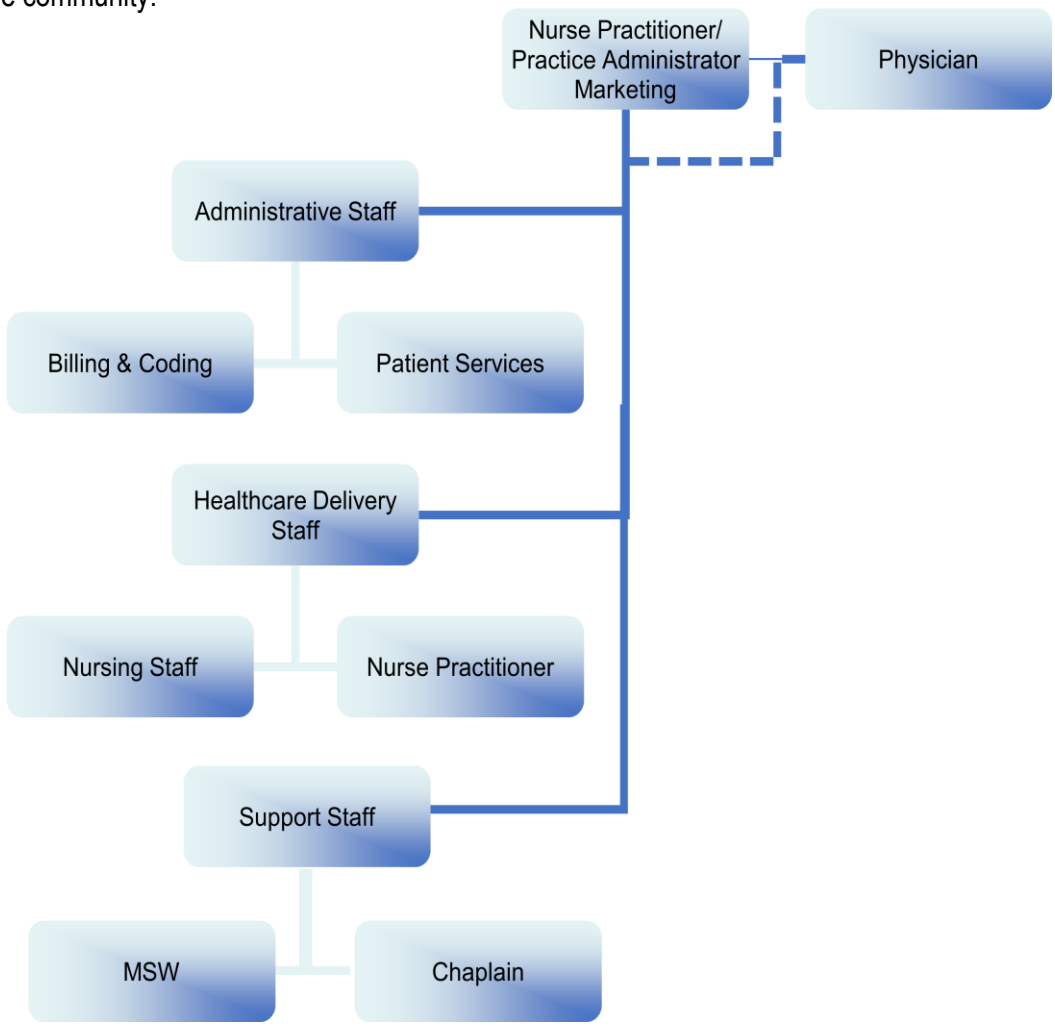
ORGANIZATION AND MANAGEMENT

The Institute of Medicine (2010) recommended that Advance Practice Registered Nurses (APRN), including nurse practitioners (NP), practice to the full extent of their education and training. NPs are advanced practice registered nurses. They have obtained graduate level degrees at the master or doctoral level after completion of a baccalaureate nursing program and licensure as a registered nurse. NPs are certified by national certification bodies in their area of practice and possibly other times in areas of specialty, with recertification required approximately every five years.

Twenty-two states and the District of Columbia have passed legislation granting Nurse Practitioners full practice authority to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments including prescriptive authority under the exclusive licensure authority of the nursing boards of the states (AANP, 2017). The American Academy of Nurse Practitioners (AANP) represents over 205,000 nurse practitioners and their statistics show that in 2012, more than 900 million healthcare visits were performed by Nurse Practitioners and that number is expected to grow significantly in the years to come (AANP 2015).

Currently NPs in Kansas are licensed as APRNs and may evaluate and manage patients if they are in a collaborative practice agreement with a physician licensed in the state of Kansas (Kansas State Board of Nursing, 2016). Johnson County Palliative Care will be managed and care provided by the hospice and palliative care board certified nurse practitioner. The practice physician will remain in collaborative agreement with the nurse practitioner to meet state rules and regulations for APRN practice. The physician will be available to see patients as well.

Nursing and administrative staff are already in place within the organization. Members of a palliative care team generally include a provider, nurse, social worker and chaplain. A master's prepared social worker (MSW) will be employed on an as needed basis until the growth of the program is able to support a part or full time addition. A local church has agreed to supply chaplain services as a part of their ministry to the community.



SERVICE LINE AND MARKETING

To provide background for this business plan, scholarly data has been organized and synthesized via extensive review of the literature. Fourteen clinical studies were included in the review. The results of the eleven studies related to quality of life reviewed provide very strong evidence that outpatient palliative care improve quality of life in patients with life-limiting illness as well as the quality of life of their caregivers/family members. Two of three studies regarding 30-day hospital readmission concluded that palliative care consultation leads to a reduction in 30-day hospital readmissions (O'Connor, 2015; Gonzalo & Miller). Seven of the top ten causes of death in the United States in 2010 were chronic diseases (Center for Disease Control and Prevention [CDC], 2015). The results of the studies reviewed provide very strong evidence that outpatient palliative care improves quality of life in patients with life-limiting illness as well as the quality of life of their caregivers/family members.

The previously mentioned CAPC Public Opinion Research validated that once consumers understand what palliative care is and does, that want to have it a part of their and their family's plan of care. Hospitals have recently been mandated with decreasing hospital 30-day readmissions or experience decreased Medicare reimbursement and many are turning to palliative care as a proven method to combat this problem.

Marketing will include the CAPC definition of palliative care, as well as the services offered:

- Symptom Management – reduce physical suffering from pain, fatigue, breathlessness, nausea, vomiting and other physical symptoms
- Help with Medical Decision Making – assist with deciphering medical information, clarify goals of care as they relate to the patient and family goals, values and beliefs.
- Emotional and Coping Support – Address fear, anxiety, depression and grief
- Spiritual and Cultural Support – honor and support cultural values

Marketing this new service will begin with the nurse practitioner providing insurance companies such as Blue Cross and Blue Shield of Kansas City and United Healthcare with information about the services. Information will be forwarded to the insurance company medical directors and nurse case managers outlining the ways the outpatient palliative care services can assist them in better serving their subscribers. The clinic is listed on the National Palliative Care website. The nurse practitioner is listed in the "find a provider" section of the Hospice and Palliative Nurses Association's website. A page of the practice website is dedicated to Johnson County Palliative care with information and referral options (http://lookgoodfeelgoodbehealthy.com/johnson-county-palliative-care/). Presentations will be made to local nurse practitioner groups. Local hospitals medical staff offices will be provided with information on how to make referrals. Hospitals with higher readmission rates will be targeted. Once patients are referred and seen, prompt communication with the referring provider will be a key method of continued referrals. Office staff will be trained on palliative care and what the services will provide to enable informed conversations.

## FUNDING REQUEST/FINANCIAL PROJECTIONS

There is no funding request for this business plan. Financial projections are made based on projected revenue and costs. Cost for introduction of the new service line in minimal because it is being added to an existing practice within the current staffing model. Marketing costs will be roughly $500 and include paper, ink and time of the nurse practitioner doing presentations. The business has capacity to add another provider room 5 days a week.

Providers will be paid on a contract basis based on a percent of collections so there is no additional provider salary, benefit or tax expenditure. It is projected that 80% of the revenue will come from third party payors. When billing third party payors, Current Procedural Terminology (CPT) codes are numeric codes used to describe all medical visits, tests, procedures performed by healthcare providers. CPT codes are submitted to third party payors to request reimbursement for services performed by healthcare providers

(Practice Management Corporation, 2016). These codes can be based on time spent or level of medical decision making. The codes and average payments that will be utilized for the provision of services within Johnson County Palliative Care are as follows:

Average Reimbursement for Evaluation and Management Codes for Commercial Carriers:

| E&M | Fee Schedule |
|---|---|
| 99201 | 40.78 |
| 99211 | 21.27 |
| 99202 | 71.17 |
| 99212 | 41.59 |
| 99203 | 104.83 |
| 99213 | 63.97 |
| 99204 | 154.13 |
| 99214 | 100.09 |
| 99205 | 195.02 |
| 99215 | 141.86 |

The average co-pay patients have with commercial third party payors is $30-$45. It is difficult to predict how much patient co-insurance or deductible will be for evaluation and management visits because each company has individual contract with individual terms.

Medicare Reimbursement for Evaluation and Management Codes:

| E&M | Fee Schedule |
|---|---|
| 99201 | 41.48 |
| 99211 | 19.06 |
| 99202 | 71.02 |
| 99212 | 41.26 |
| 99203 | 102.58 |
| 99213 | 69.62 |
| 99204 | 156.71 |
| 99214 | 102.67 |
| 99205 | 197.56 |
| 99215 | 138.41 |

New CPT codes specifically for Advanced Care Planning such as discussing advanced directives, living wills etc, have recently been introduced. These codes can be utilized individually or in addition to another CPT code and are time based. These codes are:

Medicare Reimbursement for Advanced Care Planning Codes:

| E&M | Fee Schedule |
|---|---|
| 99497 (30 minutes) | 79.33 |
| 99498 (additional 30 minutes) | 69.66 |

Palliative care visits require more time than average 15 minute doctor visit due to the nature of these complex visits. Advanced care planning, goal realization and setting, caregiver support and evaluation and patient physical, emotional, mental and spiritual are areas addressed. Likely in the office setting 8-16 patients a day would be seen with an average CPT bill of a 99214 grossing $800-$1600 per day once at capacity. Home visits for patients unable to come into the office because of the severity of their illness are available and billed/paid with home visit CPT codes. Due to the time required for travel in between patients, home visits decrease the number of patients seen secondary to time for minimally increased reimbursement. It is expected this service line will be profitable within 12 months. An added service for the future would be that of cash-pay telehealth visits, for patients who are either out-of-town or too ill to travel to the office to be seen. The average telehealth visit is $50 and is not reimbursed by insurance or Medicare in the Kansas City area.

ADDENDUM 1: Focus Group Information

Focus group was held at a local church prior to a CPR class. There were 20 participants ages 22-67. Eleven were female and nine male. Participants were asked the following questions:

- Please tell me what you know about palliative care
- What is your experience with palliative care
- After being provided the CAPC definition of palliative care: what are your thoughts about palliative care?
- Would you want the option of outpatient palliative care for yourself or your family members in addition to traditional care when needed?

ADDENDUM 2: Physician/NP Questions Information

Five physicians and fifteen nurse practitioners were asked the following questions:

- What is your definition of palliative care?
- Do you see a benefit to outpatient palliative care for you and your patients?
- Do you routinely refer patients to outpatient palliative care?
- After receiving the CAPC definition of palliative care: Does this change your opinions of palliative care?
- Do you see value in a local outpatient palliative care clinic?
- Would you refer patients to a local outpatient palliative care clinic?

ADDENDUM 3: Synthesis of Literature Review

The results of the eleven studies related to quality of life reviewed provide very strong evidence that outpatient palliative care improve quality of life in patients with life-limiting illness as well as the quality of life of their caregivers/family members. The studies reviewed varied in the hierarchy of evidence, but each provided significant findings. The studies primarily focused on individuals diagnosed with cancer or children with a terminal illness. Many of these studies were specifically excluded in an effort to determine a more broad utilization of outpatient palliative care. The authors all suggest that the current, available research is heterogeneous and that more consistent, evidence-based research is indicated. Though there is inconsistency in research methodologies and definitions of terms, the consensus of the studies included in the integrative review is that outpatient palliative care is efficacious in improving quality of life for patients and their caregivers.

Three 30-day hospital readmission studies were reviewed and produced incongruent findings (O'Connor, 2015; Gonzalo & Miller, 2007; Taha, 2014). One of the three studies produced results that were not statistically significant related to palliative care consultation decreasing 30-day hospital readmission (Taha, 2014). The remaining two studies concluded that palliative care consultation leads to a reduction in 30-day hospital readmissions (O'Connor, 2015; Gonzalo & Miller). Researchers (O'Connor, 2015) determined that within palliative care consultations, those that address goals of care were associated with lower 30-day readmission rates while those that address symptom management were not. The potential for bias exists in all three studies. Selection bias, recall bias, reporting bias, misclassification bias and confounding are a few inherent variables that need to be accounted for when dealing with seriously ill or dying subjects. Diagnosis of life-limiting illness and negative presence of dementia were appropriately controlled. The O'Connor et al study (2007) appropriately controlled for Do Not Resituate (DNR) Status, Self Assessment of Health and positive depression screen while the other two studies did not. DNR, a person's perception of their health status and the presence of depression and can all influence acceptance

of palliative care and decision to return to the hospital. Agencies and organizations such as Medicare, the Centers for Disease Control (CDC) and Healthy People 2020 and have mandated hospitals decrease 30-day readmissions with monetary fines imposed if unsuccessful (Shinkman, 2014). A major goal of palliative care is to reduce re-hospitalizations. Two of the three studies reviewed provided evidence that palliative care decreases 30-day hospital readmissions.

Limitations

Quality of life with life-limiting illness is subjective, in a vulnerable population and a challenge to standardize and quantify. Statistically significant outcome measures were found incongruent in the 30-day hospital readmission studies. Selection bias in all studies is strong due to subjects not agreeing to participate or not being referred. Many of the studies evaluated the effect of inpatient palliative care, not outpatient services. The majority of palliative care studies include oncology patients however many other life-limiting diseases benefit from palliative care services. The majority of identified studies were performed outside of the United States. There are notable methodological differences in the studies. There are varying definitions of “palliative care” and “usual care”.

The three studies reviewed and evaluated regarding 30-day hospital readmission contained several confounders that were not controlled such as: religious beliefs and family values related to illness and dying, patient and family goals of care, place of residence and previous hospice/palliative care experience or exposure. Illness Severity was inappropriately controlled in the O’Connor et al (2011) and Taha et al. (2014) studies. The intention of palliative care is that initiation be early in the chronic, life-limiting disease process. Therefore, whether the illness would be severe or not, should not affect the readmission rate determined by palliative care exposure.

Summary of Review

Seven of the top ten causes of death in the United States in 2010 were chronic diseases (CDC, 2015). The results of the studies reviewed provide very strong evidence that outpatient palliative care

improves quality of life in patients with life-limiting illness as well as the quality of life of their caregivers/family members. The studies reviewed were varied in the hierarchy of evidence, but each provided significant findings.

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